UNIFORM PREADMISSION SCREENING AND REPORT FORM

This form is to be completed by a certified preadmission screening evaluator employed or contracted by a Community Services Board to determine and arrange the least restrictive disposition for an individual in need of an emergency intervention. The disposition to be recommended at the commitment hearing shall consider all least restrictive alternatives available.

DATE: _____ TIME: (from_____ to _____)
EMERGENCY CUSTODY ORDER: Magistrate Issued? ☐Yes ☐No Date and Time:_____
Law Enforcement Custody ____Yes ____No Date and Time: _____
Extended? ☐Yes ☐No ☐To identify TDO facility ☐To complete Med Eval ☐ Other _____
EVALUATION: ☐ In-person ☐Two-way electronic video and audio
DISPOSITION: ☐ **VOL** ☐**TDO** ☐ **SAFETY PLAN** ☐ **RECOMMITMENT** ☐**OTHER (explain):_____**
NAME of HOSPITAL/FACILITY: _____CASE/TDO #: _____

1. PERSONAL DATA

First Name: _____ Last Name: _____ Age: _____ Date of Birth: _____ (MM/DD/YY)

Address: _____ (Street) (City or County) (State) (Zip Code)

Phone: (___)_____ Marital Status: _____ SSN: _____

Physical Description: _____ (Sex) _____ (Race) ☐Y ☐N Hispanic Origin _____ (Height) _____ (Weight) _____ (Hair Color) _____ (Eye Color)

Emergency Contact: _____ Relationship to Person: _____

Address: _____ (Street) (City or County) (State) (Zip Code) Permission to contact? ☐Y ☐N

Phone: Home (____)_____ Work (_____)_____

Legal Guardian: ☐Y ☐N If yes, Name: _____ Phone: (____) _____

SSI: ☐Y ☐N SSDI: ☐Y ☐N Employed: ☐Y ☐ N Veteran: ☐Y ☐N ☐UNK

Insurance: ☐Y ☐N _____ (Name of Company/ Group/Plan/Number) Medicaid: ☐Y ☐N #_____

Medicare: ☐Y ☐N #_____ Part D: ☐Y ☐N # Name of plan: _____

(If under 18) School Division:_____ School Attending: _____Grade: ____ Special Education: ☐Y☐N

CSB of Residence: _____ Contacted: ☐Y ☐ N ☐N/A CSB Agency Code: _____

Name of CSB Staff Contacted:_____ Phone (____)_____

2. COLLATERAL SOURCES OF INFORMATION/CSB SERVICES: (Please ***Check*** all that apply)

☐ WRAP or Other Advance Directive ☐Individual Requesting Evaluation ☐Family/Significant Other ☐Treatment Records
☐Treating Physician/Psychiatrist ☐CSB Case Manager or Other Staff ☐Police/First Responders

Is this individual currently receiving CSB services? ☐ Yes ☐ No If yes, specify: _____

In which CSB program(s) (***Check***): ☐Mental Health ☐Substance Abuse ☐Mental Retardation

☐ Under MOT ☐Other (Specify): _____

Primary Care Coordinator/Case Manager Name/Phone: _____

3. FOR LOCAL USE –

4. PRESENTING CRISIS SITUATION AND CURRENT CIRCUMSTANCES (Including information such as what helped the person in previous crises, precipitating events, stressors, strengths, alternative decision makers, accessibility of support network, recent behaviors)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

5. MENTAL STATUS EXAM (***Check*** all that apply and add specific behaviors under findings)

Appearance: ☐ WNL ☐ unkempt ☐ poor hygiene ☐ bizarre ☐ tense ☐ rigid

Behavior/Motor Disturbance: ☐ WNL ☐ agitation ☐ guarded ☐ tremor ☐ manic ☐ impulse control ☐ psychomotor retardation

Orientation: ☐ WNL **disoriented:** ☐ time ☐ place ☐ person ☐ situation

Speech: ☐ WNL ☐ pressured ☐ slowed ☐ soft/loud ☐ impoverished ☐ slurred ☐ other

Mood: ☐ WNL ☐ depressed ☐ angry/hostile ☐ euphoric ☐ anxious ☐ anhedonic ☐ withdrawn

Range of Affect: ☐ WNL ☐ constricted ☐ flat ☐ labile ☐ inappropriate

Thought Content: ☐ WNL ☐ delusions ☐ grandiose ☐ ideas of reference ☐ paranoid ☐ obsessions ☐ phobias

Thought Process: ☐ WNL ☐ loose associations ☐ flight of ideas ☐ circumstantial ☐ blocking ☐ tangential ☐ perseverative

Perception/ Sensorium: ☐ WNL **hallucinations:** ☐ auditory ☐ visual ☐ olfactory ☐ tactile ☐ illusions

Memory: ☐ WNL **impaired:** ☐ recent ☐ remote ☐ immediate

Able to provide historical information: ☐ Y ☐ N If no, explain below in findings.

Appetite: ☐ WNL ☐ poor **Weight:** ☐ loss ☐ gain **Appetite:** ☐ increased ☐ decreased

Sleep: ☐ WNL ☐ hypersomnia ☐ onset problem ☐ maintenance problem

Insight: ☐ WNL ☐ blaming ☐ little ☐ none **Judgment:** ☐ Good ☐ impaired ☐ poor

Estimated Intellectual Functioning: ☐ above average ☐ average ☐ below average ☐ diagnosed MR

Reliability of self report (explain below): ☐ good ☐ fair ☐ poor

Explain clinically significant findings, including areas unable to assess: _____

_____

_____

_____

_____

Individual's Name: _____

6. DIAGNOSIS: DSM IV (P=Provisional, H=Historical)

Axis I: _____ Axis I: _____ Axis I : _____

Axis II: _____ Axis II: _____

Axis III: _____

Axis IV: Psychosocial and Environmental (Check): ☐Support Group ☐Social/Environmental ☐Educational

☐Occupational ☐Housing ☐Economic ☐Health Care ☐Legal System/Crime ☐Other: _____

Axis V: GAF Current: _____ Highest past year, if known: _____

7. RISK ASSESSMENT/Clinical Opinion

Mental Illness : ☐Is ☐Is Not a person with mental illness **Substance Abuse:** ☐Is ☐Is Not a person abusing substances

Temporary Detention Order and Civil Commitment Criteria (Please ***Check*** all that apply**)**

☐ There is a substantial likelihood of serious physical harm to ☐self or ☐others in the near future as a result of mental illness as evidenced by recent behavior:

☐ Caused Harm ☐ Current Attempt ☐ Recent Attempts to Harm ☐ Threatening Harm
☐ Ideation Plan: ☐ Defined ☐ Means ☐ Active Psychosis

Please describe information checked above/recent behavior: _____
_____
_____
_____

☐ Other relevant information, if any, specify: _____
_____
_____
_____

☐ There is a substantial likelihood that, as a result of mental illness, in the near future he/she will suffer serious harm due to a lack of capacity ☐ to protect him/herself from harm or ☐ to provide for his/her basic human needs*

☐ Engaging in behavior that could lead to harm
☐ Interventions designed to prevent harmful behavior have been ☐ attempted ☐ failed

Please describe information checked above/recent behavior: _____
_____
_____
_____
_____

Capacity & Willingness to Accept Voluntary Treatment/Hospitalization/Least Restrictive Alternatives

☐ Able to maintain and communicate choice
☐ Able to understand relevant information
☐ Able to understand consequences
☐ Willing to be treated voluntarily
☐ Less restrictive community alternatives than a TDO exist to serve this individual

Treatment and Support Options: ☐Considered or ☐Implemented _____
_____
_____
_____
_____

*** Not applicable under Virginia Code §19.2-169.6, 19.2-176 and 19.2-177-1**

Individual's Name: _____

8. DISPOSITION OF THE EMERGENCY EVALUATION OR EMERGENCY CUSTODY ORDER:
(Please ***Check*** one of the following dispositions)
☐ No further treatment required or ☐ individual declined referral and no involuntary action taken

☐ Referral for voluntary outpatient or community treatment other than crisis stabilization
If either of the above two are checked you may stop and sign below.

If any of the following are checked, please continue completing this form.
☐ Voluntary inpatient admission and treatment

☐ Referral for voluntary residential or ambulatory crisis stabilization services

☐ TDO
Please ***Check*** if you have ☐ explained the TDO hearing and commitment process to the
☐ individual and ☐ family or ☐ other, specify: _____

Note: If a TDO is not recommended you must inform the petitioner and on-site treating physician

Preadmission Screener Signature: _____ Print Name & CSB _____

9. MENTAL HEALTH TREATMENT HISTORY (Attach psychiatric advance directive if available): If individual has had inpatient hospitalization(s): 1)a. Approx. number of total hospitalizations: _____ 1)b. State facility?: ☐Y ☐N
2)a. Discharge date of last hospitalization:_____ 2) b. From where?: _____

Comments (optional):_____
_____
_____
_____

Psychiatrist/Private Provider:_____ Contact Info: _____

10. MEDICAL Primary Care Provider: _____ Phone (____)_____

Medical History & Current Medical Problems/Symptoms: _____
_____
_____
_____

Medication: Current prescribed psychotropic and other medications (include dosage, schedule, etc. if known)

Name	**Dose**	**Schedule**	**Name**	**Dose**	**Schedule**
1._____			7 ._____		
2._____			8 ._____		
3._____			9 . _____		
4._____			10. _____		
5._____			11. ☐ Please see attached medication list		
6._____			12. ☐ Please see attached medical addendum		

Has individual followed recommended medication and recovery plans? ☐Y ☐N ☐NA If no, please explain: _____
_____

Recent medication changes: ☐Y ☐N (If yes, add date if known & explain) _____
_____
_____

Allergies (including food) or adverse side effects to medications: ☐Y ☐N (If yes, explain) : _____
_____
_____

Individual's Name: _____

11. SUBSTANCE ABUSE ASSESSMENT And TREATMENT HISTORY: ***Check*** if no current use ☐ or please ask the individual the following questions:

Have you consumed alcohol or drugs in the last 30 days? ☐ Yes ☐ No Date of Last Use: Alcohol _____ Drugs_____

What drugs have you used in the past? _____

Have you or anyone else ever felt you had a drug or alcohol problem? ☐ Yes ☐ No

Have you ever experienced withdrawal from drugs or alcohol? ☐ Yes ☐ No If yes, check any that apply: ☐Tremors ☐Headaches ☐Vomiting ☐Nausea ☐Diarrhea ☐ Sweating ☐ Paranoia

☐ Individual refused to answer questions about drug or alcohol use

BAC: _____ Lab Results: _____Unable to Test: _____

Please check if occurred in
PAST 24 HOURS: ☐Tremors ☐ Seizures ☐DTs ☐Vomiting Blood present? ☐Y ☐N ☐Diarrhea Blood present? ☐Y ☐N

If individual has received inpatient detox services: A) Number of times in detox? _____ B) Discharge date of last detox service: _____

C) From where?:_____

12. LEGAL DATA

A) Is individual serving a sentence?: ☐ Y ☐N Explain, if known: _____

B) NGRI Conditional Release?: ☐Y ☐N C) On Probation/Parole?: ☐ Y ☐ N Contact: _____

D) Pending Legal Charges?: ☐Y ☐N If known: Nature of charges: _____
Date of hearing: _____ Court of Jurisdiction: _____ ___

13. INDIVIDUAL SERVICE PLANNING

Individuals who can assist in treatment planning (i.e., family, peer specialist, case manager, therapist, etc.)

Name	Phone No.	Relationship to Person	Does the individual want this person involved in his/her care?	
1._____			Yes☐	No☐
2._____			Yes☐	No☐
3._____			Yes☐	No☐

Preadmission Screener Signature: _____ **Date:** _____

Print Name: _____

Section 14 on page 6 need not be completed prior to referral for temporary detention order, but must be completed prior to the hearing.

Individual's Name: _____

***Section 14 below need not be completed prior to referral for temporary detention order, but must be completed prior to the hearing*.**

14. CSB REPORT TO THE COURT AND RECOMMENDATIONS FOR THE INDIVIDUAL'S PLACEMENT, CARE AND TREATMENT PURSUANT TO 37.2-816

Date: _____ Time: _____ Name of Individual: _____

(Please ***Check*** all that apply) ☐ No further treatment required

☐ Has or ☐ does not have sufficient capacity to accept treatment
☐ Is or ☐ is not willing to be treated voluntarily, therefore the CSB recommends:
- ☐ Voluntary community treatment at the ☐ CSB, specify: _____ or
  ☐ Other, specify: _____
- ☐ Voluntary admission to a crisis stabilization program, specify name of program: _____
- ☐ Voluntary inpatient treatment because the individual requires hospitalization and has indicated that he/she will agree to a voluntary period of treatment up to 72 hours and will give the facility 48 hours notice to leave in lieu of involuntary admission

☐ Meets the criteria for involuntary admission or mandatory outpatient treatment as follows: (***Check*** all applicable)

- ☐ There is a substantial likelihood of serious physical harm to ☐ self or ☐ others in the near future as a result of mental illness as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or
- ☐ There is substantial likelihood that, as a result of mental illness, in the near future he/she will suffer serious harm due to a lack of capacity ☐ to protect him/herself from harm or ☐ to provide for his/her basic human needs

Therefore the CSB recommends: (***Check*** A or B)

A☐ Mandatory outpatient treatment because ☐ less restrictive alternatives to involuntary inpatient treatment that would offer an opportunity for improvement of his/her condition have been investigated and ☐ are deemed to be appropriate, and the person ☐ has sufficient capacity to understand the stipulations of his/her treatment, ☐ has expressed an interest in living in the community and ☐ has agreed to abide by his/her treatment plan, and ☐ is deemed to have the capacity to comply with the treatment plan and ☐ understand and ☐ adhere to conditions and requirements of the treatment and services. The recommended treatment ☐ can be delivered on an outpatient basis by the ☐ CSB or ☐ designated provider(s), specify: _____

Core Services	***Program Areas***			
Outpatient Services	☐ Mental Health	☐ Substance Abuse	☐ Mental Retardation
Case Management	☐ Mental Health	☐ Substance Abuse	☐ Mental Retardation
Day Support	☐ Mental Health	☐ Substance Abuse	☐ Mental Retardation
Employment	☐ Mental Health	☐ Substance Abuse	☐ Mental Retardation
Residential	☐ Mental Health	☐ Substance Abuse	☐ Mental Retardation
☐ Consumer Run Services	☐ Mental Health	☐ Substance Abuse	☐ Mental Retardation

Additional Recommendations for Community Services:

☐ Wellness Recovery ☐ Peer Specialist Support ☐ Housing ☐ Transportation ☐ Financial Support
☐ Dental Services ☐ Nutritional ☐ Primary Health Care ☐ Nursing Home Care ☐ Entitlement
☐ Legal Assistance/ Advocacy ☐ Trauma Informed
☐ Other, specify: _____

Services checked above are ☐ actually available in the community and ☐ providers have actually agreed to deliver the services.

B☐ Involuntary admission and inpatient treatment not to exceed ☐ 30 days (initial) ☐ not to exceed 180 days (subsequent)

☐ There are no less restrictive alternatives to inpatient treatment

_____ _____
Preadmission Screener Signature Date Preadmission Screening/Board

_____
Print Name Here

_____ _____
CSB Hearing Representative Signature Date Hearing Representative CSB

Individual's Name: _____

UNIFORM PREADMISSION SCREENING FORM SUPPLEMENT

Individual's Name: _____

PERSONAL ADDENDUM

(As appropriate, individual receiving emergency services shall be offered the following opportunity to comment at the time of the preliminary evaluation and prior to the commitment hearing)

Individual has been given an opportunity to comment:

☐ **Yes (see below comments)** ☐ **Yes, and does not choose to comment**

☐ **No, explain:** _____

INDIVIDUAL COMMENTS

1. How would you describe the current situation? _____

_____

_____

_____

_____

2. What do you think would be most helpful to you right now? _____

_____

_____

_____

_____

3. Are there any particular people you would like to be involved in your care and treatment (such as family members, friends, peers)? _____

_____

_____

4. Are there things you've already tried to help manage the current situation? _____

_____

_____

_____

_____

5. What are your top three strengths? _____

_____

_____

_____

6. Would you like to comment on anything else? _____

_____

_____

_____

_____

_____

_____

Individual's Name: _____

Individual's Signature _____ **Date:** _____